

Fill in only if patient label is unavailable

Name: DoB:

NHI: Phone:

Address:

**SPRINGHILL REFERRAL**

# SPRINGHILL REFERRAL

**Please either: Post to – Springhill Treatment Centre, 42 Morris Street, Napier 4110**

**Or Email to –** **springhill@hbdhb.govt.nz**

**For phone enquiries, please call 06 873 4896**

**Client Details:**

Client Name:

Client Address:

Phone: Email::

DOB: NHI::

Male/Female: Marital Status:

Ethnicity (include any Iwi affiliation):

General Practitioner:

Is the client smoke free?

Dependent Children? No / Yes, how many?

Paying Child Support for any children? No / Yes

Adequate childcare provisions have been made? No / Yes

**Referrer Details:**

Referrer Name:

Organisation and Address:

Phone: Email::

Extent and frequency of contact with client:

***Please attach a copy of your Comprehensive Assessment and Go To Plan/Recovery Plan. This is not necessary for Hawke’s Bay referrals if the above documents are on ECA.***

# SPRINGHILL REFERRAL – Financial Information

**Please ensure this is filled out or the referral will be returned as incomplete.**

**Present Financial Status:**

Work and Income Benefit / Employment / Other (please state)

*(Please circle)*

Weekly payments for Child Support, court fines, loans, debts etc? Total $

**If your client is benefit supported, this must have started prior to admission at Springhill.**

DHB areas that have a contract with Springhill are as follows:

Whanganui, Wairarapa, MidCentral, Hutt Valley, Capital & Coast, Bay of Plenty & Taranaki.

Any Other Information:

Signature: Date:

Name: Designation: